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Centers for Medicare and Medicaid Services
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March 15, 2013

RE: Draft Letter to Issuers on Federally-facilitated and State Partnership Exchanges

To Whom It May Concern:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-referenced draft letter to issuers, published by the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services (CMS) on March 1 ("Draft Letter"). NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the country, and is a Section 501(c)(3) tax-exempt organization.

Our comments address one portion of the Draft Letter: Chapter 1, Section 1, subsection *ii* (Essential Community Providers).

The Draft Letter describes the standards CMS will use to certify health plans as meeting the criteria set forth in the Affordable Care Act (ACA) and its implementing regulations to offer a qualified health plan (QHP) on a federally-facilitated Exchange (FFE) in Calendar Year 2014. The letter is of high importance to FQHCs and other safety-net providers, because it operationalizes the certification requirement that QHPs include "essential community providers" (ECPs) in their networks. While the guidelines in the letter are mandatory only to the FFEs, and serve as guidance for state plan management partnership Exchanges, we assume that States establishing certification requirements for their independent Exchanges in the months to come will also look to the standards in the Draft Letter.

Rigorous implementation of the ACA provisions on ECPs is critical for the Exchanges to offer adequate coverage in medically underserved areas. NACHC is concerned that the standards in the Draft Letter do not go far enough to guarantee strong representation of ECPs in QHP networks. In particular, effective primary care is the foundation of many of the ACA's reforms, and FQHCs are the chief source of primary care for low-income individuals who will have access to affordable health insurance coverage for the first time as a result of the ACA. CMS should establish more stringent requirements for inclusion of FQHCs (the one category of ECPs devoted to comprehensive primary care) in QHPs' networks on the FFEs. Moreover, the standards CMS applies to ensure enrollees have meaningful access to ECPs should take into account the demographics and geographical features of a plan's service area – not simply the number of ECPs located in the service area. Accordingly, NACHC proposes below various revisions to the "20% safe harbor" and "10% minimum expectation" standards set forth in the Draft Letter.

In addition, in NACHC's view, the terms of proposed provider contracts are as important as the mere offering of contracts in determining whether ECPs are able to participate in QHPs' networks. CMS's certification review for FFEs should include a review of model provider agreements to ensure that the contract terms to be offered to ECPs meet the requirements in the ACA.

I. Background on Health Centers and Affordable Insurance Exchanges

There are, at present, more than 1200 health centers with more than 8000 sites serving more than 20 million patients nationwide. Most of these health centers receive federal grants under Section 330 of the Public Health Service Act ("PHS Act"), 42 U.S.C. § 254b, from the Bureau of Primary Health Care ("BPHC"), within HRSA. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be serving a designated medically underserved area or a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc.) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

Effective implementation of the Affordable Insurance Exchanges is important to health centers, just as health center participation is critical to the success of the Exchanges. Health centers provide cost-effective and cost-efficient primary and preventive health care to a predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA. As a result of the coverage expansion mandated by the ACA, health centers' total patient base is projected to rise from 19.5 million in 2010 to 50 million by 2019. One recent study predicted that as of 2019, health centers nationwide will serve about 4.5 million Exchange enrollees, or 9% of health centers' total patient population.[1]

In the ACA and its implementing regulations, Congress and HHS recognized the critical role of health centers and other safety-net providers in Exchange QHP networks. Specifically, Patient Protection and Affordable Care Act (PPACA) § 1311(c)(1) provides that Exchanges "shall require that to be certified a [qualified health] plan shall, at a minimum . . . include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act. . . ." (FQHCs are listed as covered entities under Section 340B of the Public Health Service Act, and hence are a category of essential community providers.) The implementing regulations specify that as a condition of certification, QHP networks must include "a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards." 45 C.F.R. § 156.235(a)(1).

[1] *See* Kaiser Comm'n for Medicaid and the Uninsured, *Community Health Centers: Opportunities and Challenges of Health Reform* (Aug. 2010), Figs. 8, 9.

In PPACA, Congress also acknowledged the critical role of FQHCs in providing coverage on the Exchanges by specifically requiring adequate payment by QHPs for services rendered by FQHCs. PPACA provides:

> If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act . . . to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under Section 1902(bb) of such Act . . . for such item or service.

PPACA § 1302(g)). Section 1902(bb) of the Social Security Act, in turn, contains the requirement that States pay FQHCs furnishing Medicaid services according to a cost-related prospective payment system (PPS) methodology. The implementing regulations repeat the statutory requirement that QHPs pay health centers according to Medicaid PPS, and notably include that requirement among the "minimum certification standards" for QHPs at 45 C.F.R. Part 156, Subpart C. *See* 45 C.F.R. § 156.235(e).

II. Comments

The Draft Letter, at pages 7-10, establishes requirements for inclusion of ECPs in provider networks on FFEs through "safe harbor" and "minimum expectation" standards.

Under the "safe harbor" standard, an issuer must show that (1) at least 20% of available ECPs in the plan's service area participate in the issuer's provider network(s); and (2) the issuer offers contracts during the coverage year to all available Indian providers in the services area, and at least one ECP in each ECP category in each county in the service area.

Under the "minimum expectation," an issuer must demonstrate that at least 10% of available ECPs in the service area participate in the issuer's provider network(s); in addition, the issuer must include a narrative justification describing how its provider networks, as currently designed and after taking into account new 2014 enrollment, provide an adequate level of service for low-income and medically underserved enrollees.

In NACHC's view, both of these standards fall far short of ensuring ECPs' participation in the networks of QHPs on the Exchanges. After all, FQHCs and other ECPs were by definition deemed *essential* in the ACA – not merely beneficial or recommended. NACHC recommends that CMS revise both the safe harbor and the minimum expectation as explained below.

A. CMS should set an ECP standard more rigorous than the regulations and should require that to obtain certification as a QHP, a health plan contract with any willing essential community provider.

NACHC did not support HHS's decision, in the implementing regulations at 45 C.F.R. Part 156 issued on March 27, 2012, to interpret the statutory requirement that QHP networks include ECPs, "where available," as merely a network adequacy requirement. PPACA § 1311(c)(1)(C). Instead, HHS would have more faithfully carried out Congress' intent had it promulgated regulations that required QHPs to contract with any willing ECP.[2]

[2] While we will not undertake a legal argument on that issue here, we do note that PPACA's statutory structure clearly conveys this intent. For example, Congress added, as a "rule of construction" interpreting PPACA § 1311(c)(1)(C), that that section "shall not be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan." No such caveat would be necessary had Congress not contemplated that QHPs would be obliged to contract with all ECPs *other than* those refusing to accept the generally applicable rate. Moreover, the structure of the statute indicates that Congress did not view the requirement that QHPs contract with ECPs as a network

Nonetheless, it is critical to note that for CMS's present purposes – establishing certification requirements on the FFEs – the regulations in Part 156 act *as a floor rather than a ceiling*. As HHS stated in the preamble to its final rule on Exchanges, "Exchanges have the discretion to set higher, more stringent standards with respect to essential community provider participation, *including a standard that QHP issuers offer a contract to any willing essential community provider*." 77 Fed. Reg. at 18,421 (Mar. 27, 2012) (emphasis added).

The rules that CMS applies here are important not just to States operating under FFEs; they will also have a broader impact because they will serve as a guide for partnership Exchanges and state-based Exchanges. It is therefore particularly important that CMS apply standards here that assure that each type of ECPs is meaningfully represented in each plan's service area. In our view, that goal will not be realized unless the health plan is required to contract with any willing ECP in the service area.

At a minimum, even if CMS chooses to set forth a more lenient "minimum expectation," CMS should revise the criteria in the Draft Letter to provide that no health plan *may enjoy a safe harbor* from the requirement to include ECPs in its network unless it commits to offering a reasonable and legally compliant contract to any willing ECP. The concept behind a safe harbor is that an entity's conduct so clearly fulfills the intent behind a statutory or regulatory scheme that the entity is exempted from making a detailed showing of compliance with the statute or regulation. NACHC submits that the "20% safe harbor" standard is far from rigorous enough to guarantee that an issuer has met the statutory directive to contract with essential community providers "where available." *See* PPACA § 1311(c)(1)(C)). On the contrary, only an "any willing provider" contracting requirement could be an effective safe harbor. We address the flaws of CMS's proposed "20% safe harbor" standard more fully below.

B. Alternatively, CMS should rigorously enforce the regulatory requirement of "reasonable and timely access" to ECPs and should recognize FQHCs' unique role in QHP networks.

Even if CMS chooses to enforce ECP standards that are no more rigorous than those outlined in the regulations at 45 C.F.R. § 156.235 – the approach indicated in the Draft Letter – the requirements CMS has proposed in the Draft Letter still fall short of the mark.

45 C.F.R. § 156.235(a) requires that the QHP issuer (1) have a sufficient number *and geographic distribution* of ECPs in its network, (2) to ensure reasonable *and timely* access, (3) to a *broad range* of such providers for low-income, medically underserved individuals in the service area. The "safe harbor" and "minimum expectation" standards that CMS has proposed in its Draft Letter do not address the three considerations indicated in italics above: geographic distribution of ECPs, population and demographic features of the service area, and adequate representation of various types of ECP.

In addition, because effective primary care is central to the reforms contained in the ACA, FQHCS – medical home to millions of uninsured individuals who will soon have access to coverage on the Exchanges – are uniquely important as essential community providers. The ECP standards applied on the federally-facilitated Exchanges should reflect the unique role of FQHCs.

The revisions we propose to the "safe harbor" and "minimum expectation" standards reflect the above four considerations.

1. **CMS should establish an "any willing ECP" standard as the "safe harbor" from the statutory and regulatory ECP requirements.**

The proposed "20% safe harbor" requirement is clearly insufficient when applied to FQHCs. As noted above, readily available primary care services are essential to high-quality and cost-effective

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adequacy requirement: PPACA § 1311(c)(1) contains separate paragraphs addressing network adequacy (PPACA § 1311(c)(1)(B)) and the inclusion of ECPs in provider networks (PPACA § 1311(c)(1)(C)).

Exchange coverage, and primary care providers in general are in a shortage. Since FQHCs presently provide primary care to millions of potential Exchange enrollees, participation of *all* available FQHCs in the network would be necessary in order to demonstrate that enrollees have "reasonable and timely access" to FQHCs as a type of primary care provider.

In addition, FQHCs that receive Section 330 funds, by definition, have been designated to serve a medically underserved area or an underserved population (homeless, migrant, or residents of public housing) within an area. This designation alone shows that BPHC has determined the FQHC to be an essential source of care in that location or for that group, and that the regulatory requirement of "reasonable and timely access" to an ECP would not be met without the FQHC's participation. For this reason, the only acceptable "safe harbor," particularly with respect to FQHCs, would be a requirement that the issuer commit to offering a reasonable and legally compliant contract to any willing ECP.

The added requirement in the Draft Letter that the issuer show it has offered a contract to "at least one ECP in each ECP category in each county" in the service area does not make the network requirement any more rigorous. This standard plainly fails to provide for "reasonable and timely access" to a "broad range" of ECPs because it does not take population, demographics, or geographical features of a service area into account. For example, highly populous counties with a large number of medically underserved residents – for example, Los Angeles County, California (population 10 million) and Cook County, Illinois (population 5.2 million) – would not be adequately served by one health center participating in a health plan. Similarly, in a geographically large, rural county, a health center located in one corner of the county would not be accessible in a "timely" fashion to plan enrollees who live on the other side of the county. Only an issuer that has included any willing ECP in its network could meet a "safe harbor" standard. Below, for purposes of the "minimum expectation" requirement, we propose different geographical / population requirements as alternatives to the "one ECP per type per county" approach, which we believe serves no purpose.

2. **The "minimum expectation" standard should be more rigorous.**

CMS's proposed "10% minimum expectation" standard requires only that an issuer demonstrate that at least ten percent of the ECPs in the plan service area participate in the issuer's networks, and that the issuer provide a narrative justification concerning the adequacy of its network. In NACHC's view, this standard fails by a wide margin to provide for "reasonable and timely access" to ECPs, as required by 45 C.F.R. § 156.235(a)(1).

It is implausible that a plan could provide reasonable access when it contracts with only one in ten ECPs. In addition, the standard CMS proposes does not consider the population, demographics, or geography of the service area or the distribution of different types of ECPs. Conceivably, a plan whose service area includes 50 ECPs could meet the "minimum expectation" by contracting with only five family planning providers, or only five Ryan White providers, and no FQHCs or safety-net hospitals. This "minimum expectation" standard dilutes the ECP requirements in the regulation to the point that they have almost no effect.

NACHC suggests two major revisions to the "minimum expectation" standard. First, CMS should use a higher percentage standard, applicable to all ECPs. We propose that CMS require an issuer to include in its network at least 50% of all ECPs in the service area.

CMS should implement two other requirements *in addition to* the fifty-percent rule: a specific enrollee-to-provider ratio, and a maximum mileage or driving time to the closest ECP provider. Both the ratio and the proximity requirement would be individualized for each ECP type, to take into account the importance of that type of provider to the network and the expected volume of service usage. Because of the centrality of primary care providers in Exchange coverage, the ratio and proximity requirements for FQHCs would be more rigorous than for other ECPs. As an example, CMS might require that for

FQHCs, the issuer contract with FQHCs in sufficient volume to ensure that the ratio of enrollees to individual FQHC physicians is at least 1:2000. With respect to geography, CMS could require that the issuer's network include an FQHC within 10 miles or 15 minutes' driving distance from each enrollee's residence. If the issuer would be required to contract with more than 50% of ECPs in order to meet the enrollee-to-provider ratio and the proximity requirement for each ECP category, then the more rigorous requirement would prevail.

The minimum standard that CMS has articulated – based only on a (low) percentage of ECPs in the issuer's network, without any consideration of population, geography, and ECP provider types – gives no effect to the regulatory requirements. NACHC strongly urges CMS to revise the "minimum expectation" rule so that the regulatory requirements concerning ECPs have some "teeth" in states operating under federally-facilitated Exchanges.

C. CMS should more clearly explain how it will determine whether an issuer has included ECPs in its network and should review model provider agreements for ACA compliance.

NACHC requests that CMS, in its final Letter to Issuers, clarify the showing that an issuer must make with respect to the issuer's present or future contracting relationships with ECPs in order to meet the "safe harbor" and "minimum expectation" requirements. As we understand the process, issuers will be submitting their applications next month, in April 2013. Issuers will learn of CMS's certification decision, and (if successful) sign an agreement with CMS in September 2013, in time to begin open enrollment on October 1. Presumably, issuers will finalize their provider agreements for plans offered on the Exchanges only after receiving the CMS certification decision.

In this setting, CMS can best monitor the adequacy of the representation of ECPs in the issuer's provider network by (1) requiring the issuer to identify the ECPs to which it intends to offer a contract, *and* (2) requiring the issuer to provide for CMS's review model provider agreements for each ECP type in order for CMS to evaluate whether the contract terms are reasonable and legally compliant. CMS should *not* accept as evidence of an ECP's participation in an issuer's plan the issuer's representation that the ECP presently participates in other products offered by the issuer, or the issuer's representation that the issuer merely has offered or will offer the ECP a contract (without any evidence of contract terms).

Specifically, the following statements in the Draft Letter are unclear or do not indicate a rigorous review by CMS:

- With respect to both the "20% safe harbor" and the "minimum expectation," the Draft Letter states that an issuer must demonstrate that a certain portion of the ECPs in the service area "participate in the issuer's network(s)." Issuers could interpret this (particularly "network(s)") as meaning that the issuer may demonstrate adequate ECP representation in an Exchange QHP that the issuer intends to offer merely by showing that the ECP currently participates in a different product (for example, a Medicaid managed care plan) that the issuer offers. It is not reasonable to assume based on the ECP's participation in the Medicaid plan that the ECP will participate in the issuer's Exchange plan in 2014, as the Medicaid plan may offer more acceptable terms, or the ECP may have little remaining capacity to take on new patients.
- The Draft Letter states (with respect to the "one ECP per type per county" rule in the "20% safe harbor") that "the issuer [must] *offer[] contracts during the coverage year to*" certain ECPs. This wording, too, is inadequate, because a mere representation that a contract has been offered does not enable CMS to determine if the issuer is offering the ECP reasonable, legally compliant terms.

We want to emphasize that for ECPs, the terms of proposed provider contracts are as important as the mere offering of contracts in determining whether it is feasible to participate in QHPs' networks. This is why it is particularly important that CMS require, as a condition of certifying a QHP on a federally-facilitated Exchange, that issuers present model agreements with each type of ECP for CMS's review. Such review would be similar to the type of review that CMS undertakes when it determines, under Medicaid, whether a State's contract with a managed care organization will ensure sufficient provider network participation to meet statutory and regulatory requirements. PPACA's provisions on Exchanges, like the Medicaid statute, impose specific rules for contracting with categories of providers. CMS will have no means of determining whether those requirements are met unless, as administrator of the FFE, CMS engages in a more searching review of potential contracts with providers than is indicated in CMS's Draft Letter.

Such review is important to health centers because health centers' participation in QHPs' networks will be largely contingent on each health center's ability to secure payment at its Medicaid PPS rate, or at a minimum, a level sufficient to ensure that its costs of providing care to Exchange enrollees.[3] Both PPACA and its implementing regulations require (as a condition of QHP certification) that this payment requirement be met – with the regulations including a qualification that a QHP and FQHC may agree upon a rate other than Medicaid PPS so long as the rate is at least equal to the QHP's generally applicable rate. *See* PPACA § 1302(g); 45 C.F.R. § 156.235(e). It would be difficult as a practical matter for an FQHC to participate in a plan on the Exchange unless the issuer offers a contract that complies with the legal requirements.

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Thank you for the opportunity to comment on CMS/CCIIO's Draft Letter to Issuers. While it is informal, this piece of guidance is very important to providers, and NACHC appreciates the opportunity to provide input. Please do not hesitate to contact me by telephone at (202) 296-0158 or by e-mail at rschwartz@nachc.org if you require any clarification on the comments presented above.

Sincerely,

Roger Schwartz
Associate Vice President of Executive Branch Liaison

[3] Obtaining adequate payment is particularly important for health centers because Section 330 of the PHS Act requires that a health center grantee "[make] and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled . . . . to medical assistance under . . . [a] private health insurance program ." 42 U.S.C. § 254b(k)(3)(F). The reason that Congress, in Section 330, required health centers to seek sufficient payment from all payors was to ensure that Section 330 grant funds, dedicated to covering the costs of serving uninsured and underinsured individuals, would not be diverted to subsidize the costs of serving patients with full insurance coverage. Congress reiterated this obligation in the context of QHPs operating on the Exchanges by requiring payment to FQHCs at the Medicaid PPS rate in PPACA § 1302(g). Indeed, CMS/CCIIO has recognized Congress' endorsement of adequate payment to FQHCs in its conclusion that when a QHP enrollee receives services from an FQHC that has not contracted with the QHP, "the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the plan enrollee." Letter of June 8, 2012 from Timothy Hill, Dep. Director, CCIIO, to Dan Hawkins, Senior VP, NACHC.